

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH St Marys 15886
 County St Marys (64)
 Village or City Park Hall No. St.; Ward
 2 FULL NAME Alexandria Armstrong
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 280

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
 4 COLOR OR RACE B
 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 (Write the word)
 6 DATE OF BIRTH Sept 14, 1846
 (Month) (Day) (Year)
 7 AGE 69 yrs. 1 mos. 1 ds.
 If LESS than 1 day, hrs. OR min. ?
 8 OCCUPATION no.
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 9 BIRTHPLACE (State or country) Ma

PARENTS

10 NAME OF FATHER Wm. Knowlton
 11 BIRTHPLACE OF FATHER (State or country) Ma
 12 MAIDEN NAME OF MOTHER Doris Knowlton
 13 BIRTHPLACE OF MOTHER (State or country) Ma

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Knowlton(Address) Ridge

15 Sept 14, 1915 Wm. Knowlton
 Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 14, 1915
 (Month) (Day) (Year)
 17 I HEREBY CERTIFY, That I attended deceased from , 1915, to , 1915,
 that I last saw h alive on , 1915,
 and that death occurred on the date stated above, at 8 a m.
 The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage
 (Duration) 1/2 hrs. 1 mos. 1 ds.

Contributory
Secondary

Sept 15, 1915 (Duration) 1 hrs. 1 mos. 1 ds.
 (Signed) Wm. Knowlton M. O.
 (Address) Ridge

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.
 Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hermansville DATE OF BURIAL Sept 15, 1915
 20 UNDERTAKER Lewis Clark ADDRESS Valley Ln

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

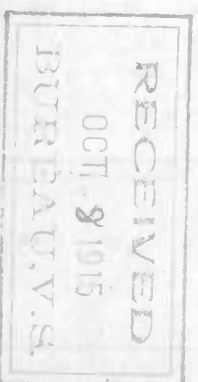
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "I caler," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Pronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal, peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 15887
County St. Mary's
Village or City Valley Lee (No. 60)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 281

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Moulton A. Bohanan

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|---|---|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDDED, DIVORCED (Write the word) <u>Widowed</u> |
| 6 DATE OF BIRTH <u>Oct</u> — <u>1832</u> (Month) (Day) (Year) | | |
| 7 AGE <u>83</u> yrs. — mos. — ds. | | If LESS than 1 day, hrs. OR min. ? |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | |
| 9 BIRTHPLACE (State or country) <u>St. Mary's County, Md.</u> | | |
| PARENTS | 10 NAME OF FATHER <u>Phil Peacock</u> | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>St. Mary's Co., Md.</u> | |
| | 12 MAIDEN NAME OF MOTHER <u>Sallie Greenwell</u> | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>St. Mary's County</u> | |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. W. Ridgell
(Address) Valley Lee, Md.

15 Filled Sept. 23rd 1915 by Burp F. Redman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 22, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30th, 1915, to Sept. 21st, 1915, that I last saw her alive on Sept. 21st, 1915, and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Hemiplegia

(Duration) — yrs. — mos. 22 ds.

Contributory (Secondary) _____

(Duration) — yrs. — mos. — ds.

(Signed) T. Horner Lynch, M. D.
Sept. 23, 1915 (Address) Valley Lee, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St. Georges Church DATE OF BURIAL Sept. 24th 1915
20 UNDERTAKER Lewis T. Clarke ADDRESS Great Mills

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

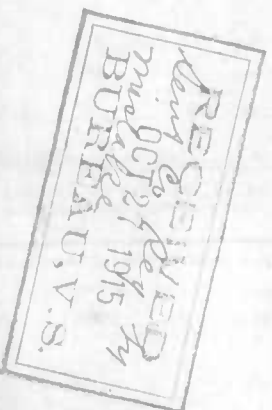
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

St Marys

15888

(104)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

2811

Village or City

near Charlotte Hall

(No.)

St;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Eustel M. Braslow

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*Colored*5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)*Single*

6 DATE OF BIRTH

September 14, 1915
(Month) (Day) (Year)

7 AGE

3 yrs. 26 ds.
If LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

St Marys Co

PARENTS

10 NAME OF FATHER

Charles Braslow

11 BIRTHPLACE OF FATHER

(State or country)

St Marys Co

12 MAIDEN NAME OF MOTHER

Flora Braslow

13 BIRTHPLACE OF MOTHER

(State or country)

Charles Co., Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Braslow

(Address)

Charlotte Hall

15

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 23rd, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

*on Sept 21, 1915, to*that I last saw him alive on *Sept 21, 1915*and that death occurred on the date stated above, at *8:36 P. M.*

The CAUSE OF DEATH* was as follows:

Elderly, Colic

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

Morgan S. Sostrom, M. D.

191

(Address)

Mechanicville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mt Calvary Cemetery**Sept 24, 1915*

20 UNDERTAKER

ADDRESS

*Wm Carter**Charlotte Hall*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

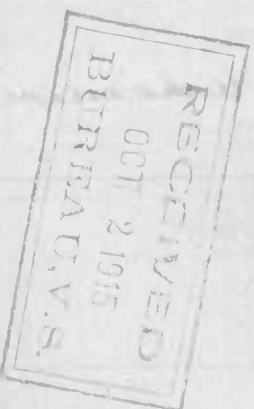
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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| 1 PLACE OF DEATH | | | STATE OF MARYLAND | |
|--|--|---|---|-----------------------------------|
| County <u>St. Mary's</u> | | | CERTIFICATE OF DEATH | |
| Village or City <u>Briarcliff</u> (No. <u>104</u>) | | | Registration Dist. No. <u>286</u> | |
| 2 FULL NAME <u>May Lillian Carter</u> | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Single</u> (Write the word) | | |
| 6 DATE OF BIRTH <u>5-4-1915</u> (Month) (Day) (Year) | | | | |
| 7 AGE <u>4</u> yrs. <u>—</u> mos. <u>—</u> ds. If LESS than 1 day, <u>—</u> hrs. OR <u>—</u> min. ? | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | |
| 9 BIRTHPLACE (State or country) <u>Ind</u> | | | | |
| PARENTS | 10 NAME OF FATHER <u>Albert Carter</u> | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u> | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Margaret Woodland</u> | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Albert Carter</u> (Address) <u>Briarcliff, Md.</u> | | | | |
| 15 Filed <u>9-2-1915</u> <u>N. V. Palmer</u> REGISTRAR | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | |
| 16 DATE OF DEATH <u>9-2-1915</u> (Month) (Day) (Year) | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>9-1-1915</u> , 191 <u>5</u> , to <u>9-2-1915</u> , 191 <u>5</u> , that I last saw him alive on <u>9-1-1915</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>8 a</u> m. | | | | |
| The CAUSE OF DEATH * was as follows: <u>Enteritis</u> | | | | |
| Contributory <u>Impaired feeding</u> Secondary | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State, <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? Former or usual residence | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Sacred Heart</u> | | | | DATE OF BURIAL <u>9-2-1915</u> |
| 20 UNDERTAKER <u>Richard Woodland</u> | | | | ADDRESS <u>at home</u> |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

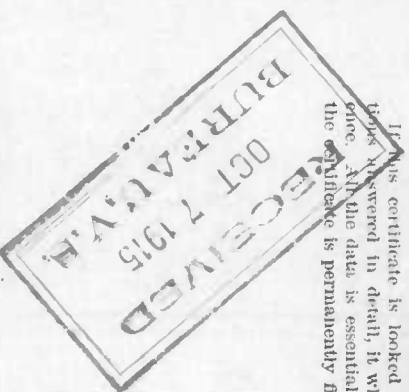
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Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more, precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misadventure as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

This certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. After the date is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

191

REGISTRAR

15890

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, that I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Contributory

Secondary

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

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1 PLACE OF DEATH

15891

County St. MarysVillage or City Drayden(No. 64)

St: Ward)

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William Stephen Coppage

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|---------------------------------|---|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u> |
| 6 DATE OF BIRTH <u>Jan 9th</u> , 1842 (Month) (Day) (Year) | | |
| 7 AGE <u>73</u> yrs. <u>8</u> mos. <u>2</u> ds. OR LESS than 1 day, ... hrs. OR ... min. ? | | |

8 OCCUPATION
(a) Trade, profession, or particular kind of work Retired Farmer (8 yrs)
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)
Queen Anne's Co Md

| | |
|---------|---|
| PARENTS | 10 NAME OF FATHER <u>John Coppage</u> |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Delaware</u> |
| | 12 MAIDEN NAME OF MOTHER <u>Nickerson</u> |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u> |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. S. Coppage(Address) 250 Patterson Park

15

Filed Sept 11th, 1915

Benj. F. Nickman
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 11th, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug 20th, 1915, to Sept 11th, 1915,
that I last saw him alive on Sept 10th, 1915

and that death occurred on the date stated above, at 2nd A m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 3 mos. ... ds.
Contributory (Secondary) Aspiration Pneumonia

(Duration) yrs. ... mos. 1 ds.
(Signed) Arthur Hebb, M. D.
Sept 11th, 1915 (Address) Porto Bello, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Poplar Hill Church Sept 12th, 1915
20 UNDERTAKER Levi F. Clarke ADDRESS Great Mills

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

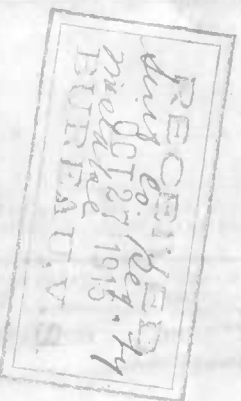
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH <i>St. Mary's</i> 15892 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <i>St. Mary's</i> | | Registered No. <i>284</i> | |
| near <i>Huntersville</i> | | St.; Ward) | |
| Village or City (No. <i>170</i>) | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <i>Edmonia Dorsey Curtis</i> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <i>Female</i> | 4 COLOR OR RACE <i>negro</i> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Widowed</i> | |
| 6 DATE OF BIRTH <i>June 15th, 1861</i> (Month) (Day) (Year) | | | |
| 7 AGE <i>54 yrs. 7 mos. 26 ds.</i> If LESS than 1 day, hrs. OR min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Housewife</i> (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) <i>St. Mary's Co. Md</i> | | | |
| PARENTS | 10 NAME OF FATHER <i>John W. Dorsey</i> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <i>St. Mary's Co. Md</i> | | |
| | 12 MAIDEN NAME OF MOTHER <i>Rosa Dorsey</i> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <i>St. Mary's Co. Md</i> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>J. W. Rich</i> (Address) <i>Mechanicville Md</i> | | | |
| 15 <i>Filed Sept 11, 1915</i> <i>Morgan & S. Thornton</i> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <i>Sept 10th, 1915</i> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <i>May 15, 1915</i> to <i>Sept 22, 1915</i> , that I last saw him alive on <i>Sept 22, 1915</i> , and that death occurred on the date stated above, at <i>8 P.</i> m. | | | |
| The CAUSE OF DEATH* was as follows: <i>Chronic Diffuse Nephritis</i> (Duration) <i>6</i> yrs. <i>6</i> mos. <i>6</i> ds. Contributory (Secondary) <i>Valvular Heart Disease</i> (Duration) <i>3</i> yrs. <i>3</i> mos. <i>3</i> ds. (Signed) <i>J. W. Rich</i> , M. D. <i>Sept 11, 1915</i> (Address) <i>Mechanicville Md</i> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <i>6</i> yrs. <i>6</i> mos. <i>6</i> ds. In the State <i>6</i> yrs. <i>6</i> mos. <i>6</i> ds. Where was disease contracted, If not at place of death? Former or usual residence | | | |
| 19 PLACE OF BURIAL OR REMOVAL <i>St. Joseph's Cemetery</i> | | DATE OF BURIAL <i>Sept 11, 1915</i> | |
| 20 UNDERTAKER <i>B. B. Love</i> | | ADDRESS <i>Morgan & S. Thornton</i> | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

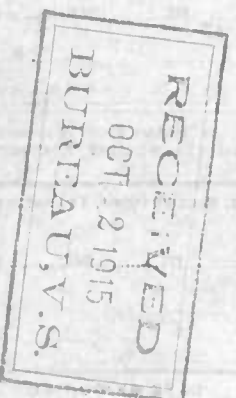
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

15893

County

Village or City

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Feb 16th, 1878 (Month) (Day) (Year)

7 AGE 39 yrs. 6 mos. 22 ds. 1 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) St. Mary's Co. Md

10 NAME OF FATHER Truman Carter

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Jane Carter

13 BIRTHPLACE OF MOTHER (State or country) St. Mary's Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Dorsey

(Address) Charlotte Hall. Md

15 Filed Sept 30th, 1915 Morgan V. Sotherton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 7th, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1914 to Sept 6th, 1915.

that I last saw her alive on Sept 6th, 1915.

and that death occurred on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) 1 yrs. mos. ds.

Contributory Valvular Heart Disease

Secondary Gaugrene Septic (Duration) yrs. 6 mos. ds.

(Signed) J. H. Rich, M. D.

Sept 7, 1915 (Address) Mechanicville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Mary's Cemetery Sept 8th, 1915

20 UNDERTAKER ADDRESS

Sydney Dent Du Bois

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

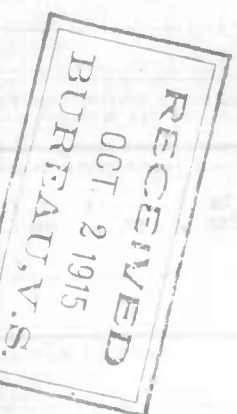
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | | | | |
|---|-----------------------------|--|---|--|--|---|--|--|
| 1 PLACE OF DEATH County <u>St. Marys</u> | | | 15894 | | | STATE OF MARYLAND CERTIFICATE OF DEATH | | |
| Village or City <u>Cornfield Harbor</u> | | | (No. <u>104</u>) | | | Registration Dist. No. <u>280</u> | | |
| 2 FULL NAME <u>Rose Yolley Haudy</u> | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>B</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word) | | | | | | |
| 6 DATE OF BIRTH <u>July 20, 1914</u> (Month) (Day) (Year) | | | | | | | | |
| 7 AGE <u>2</u> yrs. <u>2</u> mos. <u>ds.</u> If LESS than 1 day, <u>hrs.</u> OR <u>min.</u> ? | | | | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | | | | |
| 9 BIRTHPLACE (State or country) <u>Md.</u> | | | | | | | | |
| PARENTS | | | | | | | | |
| 10 NAME OF FATHER <u>Harry Haudy</u> | | | | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u> | | | | | | | | |
| 12 MAIDEN NAME OF MOTHER <u>Rosie Holly</u> | | | | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u> | | | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James Haudy</u> (Address) <u>Cornfield Harbor</u> | | | | | | | | |
| 15 <u>Sept 21</u> , 1914 <u>P. H. Boyd</u> Filed REGISTRAR | | | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | | |
| 16 DATE OF DEATH <u>Sept 20, 1914</u> (Month) (Day) (Year) | | | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h _____ alive on _____, 191____, and that death occurred on the date stated above, at <u>2 P</u> m. The CAUSE OF DEATH * was as follows: <u>Cholera Infantum</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory Secondary (Signed) <u>P. H. Boyd</u> (Duration) _____ yrs. _____ mos. _____ ds., M. O. <u>Sept 21, 1914</u> (Address) <u>Ridge</u> * State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL. | | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State, _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____ | | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Scotland</u> | | | | | | DATE OF BURIAL <u>Sept 21, 1914</u> | | |
| 20 UNDERTAKER <u>James Haudy</u> | | | | | | ADDRESS <u>C. Haudy</u> | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

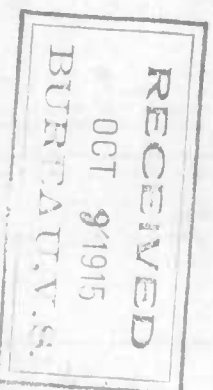
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reinforced head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 15895
 County St. Marys
 Village or City Great Mills (No. _____ St.; _____ Ward)
 2 FULL NAME Joseph Price Hazel.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
 (Write the word)

6 DATE OF BIRTH July 19, 1915
 (Month) (Day) (Year)

7 AGE 29 yrs. 1 mos. 29 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) St. Marys Co Md

10 NAME OF FATHER Arthur M Hazel

11 BIRTHPLACE OF FATHER (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Lena P. Sundling

13 BIRTHPLACE OF MOTHER (State or country) Washington D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur M Hazel

(Address) Washington D.C.

15 Filed Sept 19 1915 B. F. Medman
 REGISTRAR

16 DATE OF DEATH Sept 18, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1915, to Sept 18, 1915, that I last saw him alive on Sept 17, 1915

and that death occurred on the date stated above, at 4 a.m.
 The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial pleurisy.

(Duration) _____ yrs. _____ mos. _____ ds.
 Contributory Hemophilia
 Secondary

(Signed) C. G. Brown M. D.
Sept 19, 1915 (Address) Red Gate Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St Nicholas DATE OF BURIAL Sept 19, 1915

20 UNDERTAKER William Mattingly ADDRESS Great Mills.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

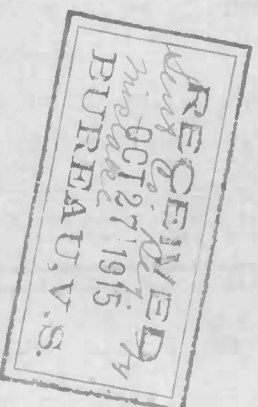
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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

15896

County

St. Marys

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

8282

Village or City

Beaune

(No.

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Harvey Alonius Heritt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male
4 COLOR OR RACE white
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH

May 23rd, 1915
(Month) (Day) (Year)

7 AGE

3 yrs. 3 mos. ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE

(State or country)

St. Marys Co Md

PARENTS

10 NAME OF FATHER

Hiram Heritt

11 BIRTHPLACE OF FATHER (State or country)

St. Marys Co Md

12 MAIDEN NAME OF MOTHER

Madeline Long

13 BIRTHPLACE OF MOTHER (State or country)

St. Marys Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hiram Heritt

(Address)

Beaune

15

Filed

1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

September 10, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 23, 1915, to Sept 10, 1915,

that I last saw him alive on Sept 10, 1915,

and that death occurred on the date stated above, at 9 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral + Marasmus

Contributory
Secondary

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed)

E. F. Brown

M. D.

Sept 11, 1915. (Address) Red Gate Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meadow Neck

Sept 11, 1915

20 UNDERTAKER

ADDRESS

Mr. Telement Mattingly

Lencard

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County

St. Mary's 15897

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 284

Village or City

Mechanicsville

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles Irvine Holt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

negro

5 SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Apr 8

1915

(Month)

(Day)

(Year)

7 AGE

4 yrs. 2 mos. 27 ds.

1 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE

(State or country)

St. Mary's Co. Md.

PARENTS

10 NAME OF FATHER

Wm. Hays Holt

11 BIRTHPLACE OF FATHER (State or country)

St. Mary's Co. Md.

12 MAIDEN NAME OF MOTHER

Susan Young

13 BIRTHPLACE OF MOTHER (State or country)

St. Mary's Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Rich

(Address)

Mechanicsville Md.

15

Filed Sept 30th 1915 Morgan K. Sothman

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 4th

1915

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from July 20th 1915 to Sept 4th 1915.that I last saw him alive on Aug 20th 1915

and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. 1 1/2 mos. ds.

Contributory Secondary

(Signed)

J. W. Rich

M. D.

Sept 4th 1915 (Address) Mechanicsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Joseph's Cemetery Sept 4th 1915

20 UNDERTAKER

ADDRESS

Mason Herbert Mechanicsville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

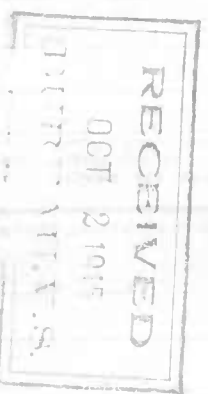
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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15898

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 283

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Mary's

Village or City Steeley wood (No. md)

St: _____ Ward _____

2 FULL NAME Mary Janiger

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Sept 11 (Month) (Day) (Year)

7 AGE 33 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Leroy Dorsey

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER South Knover

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Frank Janiger

(Address) Steeley wood, md

15 Filed _____, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 16, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1915, to Sept 16, 1915, that I last saw him alive on Sept 13, 1915

and that death occurred on the date stated above, at 4 p.m. The CAUSE OF DEATH* was as follows:

Tuberculosis
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. O. Miller, M. D. Sept 16, 1915 (Address) Dockville md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St. Johns Cemetery DATE OF BURIAL Sept 17, 1915

20 UNDERTAKER N.C. Mallory ADDRESS Leonardton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scullery*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| 1 PLACE OF DEATH | | | 15899 | | 104 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|--|---|--|--------------------------------------|--|-----------------------|--|---|--|
| County <u>St. Mary's</u> | | | Village or City <u>Mechanicville</u> | | St. Ward | | Registered No. _____ | |
| 2 FULL NAME <u>Joseph Herman Johnson</u> | | | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | | |
| 3 SEX <u>male</u> | | 4 COLOR OR RACE <u>negro</u> | | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>single</u> | | | | |
| 6 DATE OF BIRTH <u>Mar 10th 1915</u> | | (Month) (Day) (Year) | | | | | | |
| 7 AGE <u>to 6 mos. 14 ds.</u> | | It LESS than 1 day, ____ hrs. OR ____ min. ? | | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | | | | |
| 9 BIRTHPLACE (State or country) <u>St. Mary's Co. Md.</u> | | | | | | | | |
| PARENTS | 10 NAME OF FATHER <u>George Barber</u> | | | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>St. Mary's Co. Md.</u> | | | | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Annie Johnson</u> | | | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>St. Mary's Co. Md.</u> | | | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | | | | |
| (Informant) <u>Alfred Johnson (brother)</u> | | | | | | | | |
| (Address) <u>Mechanicville Md.</u> | | | | | | | | |
| 15 <u>Sept 24th 1915</u> <u>Borgan & Sotheron</u> | | | | | | | | |
| REGISTRAR | | | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | | |
| 16 DATE OF DEATH <u>Sept. 24th 1915</u> | | | | | | | | |
| (Month) (Day) (Year) | | | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Sept 10th 1915</u> to <u>Sept 10th 1915</u> | | | | | | | | |
| that I last saw him alive on <u>Sept 10th 1915</u> | | | | | | | | |
| and that death occurred on the date stated above, at <u>3 P.</u> m. | | | | | | | | |
| The CAUSE OF DEATH* was as follows: | | | | | | | | |
| <u>Enterocolitis (S)</u> | | | | | | | | |
| (Duration) ____ yrs. ____ mos. ____ ds. | | | | | | | | |
| Contributory (Secondary) <u>"Catarrhal Typhoid"</u> | | | | | | | | |
| (Duration) ____ yrs. ____ mos. ____ ds. | | | | | | | | |
| (Signed) <u>Att Rich</u> , M. D. | | | | | | | | |
| <u>9/24</u> , 1915 (Address) <u>Mechanicville Md.</u> | | | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | | | | |
| At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. | | | | | | | | |
| Where was disease contracted, If not at place of death? _____ | | | | | | | | |
| Former or usual residence _____ | | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL | | | | | DATE OF BURIAL | | | |
| <u>St. Joseph's Cemetery</u> | | | | | <u>Sept 24th 1915</u> | | | |
| 20 UNDERTAKER | | | | | ADDRESS | | | |
| <u>Alfred Johnson</u> | | | | | <u>Mechanicville</u> | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of ~~any~~ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
OCT 21 1911
BUREAU

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1 PLACE OF DEATH

15900

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 383

County St. Mary'sVillage or City Clements (No., St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Street - Marshall

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|-----------------------------------|---|
| 3 SEX <u>male</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
| 6 DATE OF BIRTH <u>Sept 4</u> , 1915 (Month) (Day) (Year) | | |
| 7 AGE yrs. mos. ds. OR 1 day, hrs. If LESS than 1 day, min. ? | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) | | |
| 9 BIRTHPLACE (State or country) | | |

PARENTS

| |
|---|
| 10 NAME OF FATHER <u>Mr. J. Marshall</u> |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u> |
| 12 MAIDEN NAME OF MOTHER <u>Sarah R. Adams</u> |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u> |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. J. Marshall(Address) Clements15 Filed Sept. 4, 1915 R. B. Johnson
Dep. Secy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

| |
|---|
| 16 DATE OF DEATH <u>Sept. 4</u> , 1915 (Month) (Day) (Year) |
| 17 I HEREBY CERTIFY, That I attended deceased from, 191....., to....., 191..... that I last saw h..... alive on....., 191..... and that death occurred on the date stated above, at..... m, The CAUSE OF DEATH* was as follows: <u>Unknown</u> |
| (Duration) yrs. mos. ds. |
| Contributory Secondary |
| (Signed) <u>R. B. Johnson</u> , M. D. <u>Sept. 4</u> , 1915 (Address) <u>Morgantown</u> |

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

| | |
|---|--|
| 19 PLACE OF BURIAL OR REMOVAL <u>St. Joseph Cemetery</u> | DATE OF BURIAL <u>Sept 5</u> , 1915 |
| 20 UNDERTAKER <u>Mr. J. Marshall</u> | ADDRESS <u>Clements</u> |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH *St. Mary's* 15901
County *St. Mary's*

Village or City *Valley Lee* (No. *38*)

2 FULL NAME *Rosie Milburn*

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*

6 DATE OF BIRTH *January 29*, 1896, (Month) (Day) (Year)

7 AGE *19* yrs. *7* mos. *24* ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) *St. Mary's Co, Md.*

10 NAME OF FATHER *John H. Milburn*

11 BIRTHPLACE OF FATHER (State or country) *St. Mary's Co, Md.*

12 MAIDEN NAME OF MOTHER *Etta Greenwell*

13 BIRTHPLACE OF MOTHER (State or country) *St. Mary's Co, Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Chas. A. Wallis*
(Address) *Valley Lee, Md.*

15 Filed *2* 191

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 23*, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Aug 18*, 1915, to *Sept 23*, 1915, that I last saw her alive on *Sept 23*, 1915, and that death occurred on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *T. Horner Lynch*, M. D. *Sept 24*, 1915 (Address) *Valley Lee, Md.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNOERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

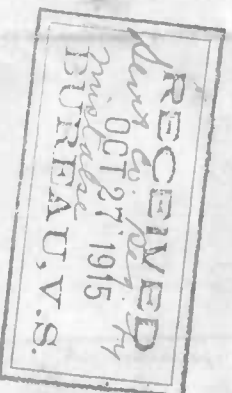
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | | | | |
|---|---|--|---|--|--|---|--|--|
| 1 PLACE OF DEATH County <u>St Marys</u> | | | 15902 | | | STATE OF MARYLAND CERTIFICATE OF DEATH | | |
| Village or City <u>Ridge</u> (No. <u>280</u>) | | | St.; Ward | | | Registration Dist. No. <u>280</u> | | |
| 2 FULL NAME <u>Mauda Thomas</u> | | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>B</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Wid</u> (Write the word) | | | | | | |
| 6 DATE OF BIRTH <u>Don't Know</u> (Month) (Day) (Year) | | | | | | | | |
| 7 AGE <u>About 53</u> If LESS than 1 day, hrs. OR min. ? | | | | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>No.</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | | | | |
| 9 BIRTHPLACE (State or country) <u>St Marys</u> | | | | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Don't Know</u> | | | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>"</u> | | | | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Don't Know</u> | | | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>"</u> | | | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James H. Spewell</u> (Address) <u>Ridge</u> | | | | | | | | |
| 15 <u>Sept 18, 1911</u> Filed REGISTRAR | | | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | | |
| 16 DATE OF DEATH <u>Sept 18, 1911</u> (Month) (Day) (Year) | | | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>1911</u> , to <u>1911</u> , that I last saw him alive on <u>1911</u> , and that death occurred on the date stated above, at <u>109</u> m. | | | | | | | | |
| The CAUSE OF DEATH * was as follows: <u>Tuberculosis (Pul)</u> | | | | | | | | |
| Contributory <u>Ext Houston</u> Secondary <u>Sept 18, 1911</u> (Duration) <u>3</u> yrs. <u>10</u> mos. <u>10</u> ds. (Address) <u>Ridge</u> | | | | | | | | |
| * State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL. | | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>yr.</u> <u>mos.</u> <u>ds.</u> In the State, <u>yr.</u> <u>mos.</u> <u>ds.</u> Where was disease contracted, If not at place of death? Former or usual residence <u>"</u> | | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Ridge</u> | | | | | | DATE OF BURIAL <u>Sept 19, 1911</u> | | |
| 20 UNDERTAKER <u>Wm Raleigh</u> | | | | | | ADDRESS <u>Ridge</u> | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

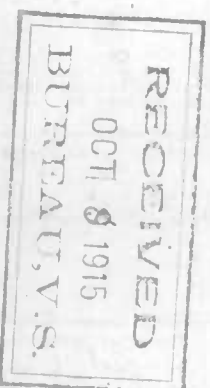
[Approved by U. S. Census and American Public Health
Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Tricety*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Tealer," etc., without more precise specification as *Ding laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, men-

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than
1 day, hrs.
OR, min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)

PARENTS

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 M maiden NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from
Sept 21, 1915, to Sept 22, 1915,
that I last saw him alive on Sept 21, 1915,
and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH * was as follows:

Contributory
Secondary

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL OR HOMICIDAL.

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OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

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[Approved by U. S. Census and American Public Health Association.]

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